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NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

BlueCross BlueShield
of North Dakota
An independent licensee of the
Blue Cross & Blue Shield Association

Waiver of Health Coverage

PAYROLL TO COMPLETE THIS SECTION.

Department Number	Agency Name	**Permanent Employment Date** *(mm-dd-yy)*
		– –

Employee Name _____ Social Security Number _____ – ____ – _____

I have been informed that I am eligible to apply for health coverage under my employer's health Benefit Plan issued by Blue Cross Blue Shield of North Dakota. I do not wish coverage for:

☐ Myself ☐ Spouse ☐ Eligible Dependents ☐ Myself and entire family

Reason coverage is being waived:

☐ I have coverage through my spouse's employer

☐ I have other individual coverage

☐ I have Medicare coverage

☐ _____

I hereby forfeit health coverage at this time. I fully understand that if I or my Eligible Dependents desire to be covered under my employer's health Benefit Plan in the future, I and my Eligible Dependents may have a Waiting Period for Preexisting Conditions and one of the following must apply:

1. If at the time I am declining coverage, it is because:
   a. I or my Eligible Dependents have other group health coverage, and that coverage is either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours) or employer contributions toward such coverage was terminated; or
   b. coverage was under COBRA at the time I declined coverage and that coverage has been exhausted.

   Under (a.) and (b.) above, I must complete a membership application within 31 days after I lose my current coverage.
2. If I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may enroll myself and my Eligible Dependents, provided that I request enrollment within 31 days of marriage, birth, adoption or placement for adoption.
3. If I do not meet requirements under 1 or 2 above, I may apply as a Late Enrollee. Late Enrollees must request enrollment during the 31 days prior to the NDPERS Annual Enrollment Period by completing a membership application.

Employee's Signature _____ Date _____ – _____ – _____

Noridian Mutual Insurance Company